AMA response to the consultation paper on a Health Professionals Prescribing Pathway Project

The AMA welcomes the Health Workforce Australia (HWA) project to deliver a consistent platform by which registered health professionals (other than medical practitioners) may undertake prescribing of medicines consistent with their scope of professional practice.

AMA members have first hand experience of the wide range of arrangements under which non-medical health practitioners prescribe medications. AMA members see the inherent risks to patient safety that arise from the inconsistency of these arrangements and, consequently, the uncertainty of who is ultimately responsible for the management and care of the patient.

Prescribing by non-medical health professionals should only occur within a consistent and sustainable medically delegated environment.

Patient safety, quality use of medicines, and effective healthcare delivery can only be secured when each member of a health professional team is practising within his or her scope of practice and is collaborating with the other team members under clear and transparent arrangements.

The National Health Workforce Planning and Research Collaboration report *Non-Medical Prescribing* (June 2010) (the NHWPRC report) identified the risks of non-medical prescribing outside of a team environment:

> “Without a team approach, patient care can easily fragment reducing quality of care and patient outcomes.” (page 43)

**Principles for nationally consistent prescribing pathway**

The following principles should underpin non-medical prescribing:

- Non-medical prescribing occurs in a medically led and delegated team environment.

- Non-medical prescribing only occurs in the context of ‘role delegation’ not ‘task substitution’.

- There must be formally documented, collaborative arrangements that ensure:
Australian Medical Association

- diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner;
- clear lines of accountability and responsibility; and
- separation of prescribing and dispensing.

- Non-medical practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education and training courses.

- Accreditation of prescribing education and training courses for non-medical practitioners must be against the same standards for accreditation of medical education and training.

- Course curriculum must include core competencies in determining when not to prescribe.

- As occurs for medical practitioners, non-medical practitioners should be closely supervised during their first years of prescribing practice.

The AMA recognises that dentists undertake appropriate high quality education and training to prescribe within their scope of practice and are, therefore, competent to prescribe independently of a medically delegated environment.

Access and efficiency

The AMA understands that the development of a non-medical health professionals prescribing pathway has been prompted by the assumption that shortages and maldistribution of the medical workforce – in particular the general practice workforce - have created barriers to health care access. The HWA project assumes that expanding non-medical health practitioners’ scopes of practice to include prescribing will improve access to medications.

As HWA is aware, the shortage of the medical workforce is currently being rebalanced. By 2014, there will be over 3,700 medical graduates annually, compared with 1,300 in 2004. While the health sector will need to provide high quality training positions for these graduates, particularly in relation to the prevocational years, the increase in medical graduates is an important consideration in developing the HWA prescribing pathway project.

There is no doubt that a greater number of prescribers will result in greater access by patients to medicines. The NHWPRC report confirmed that:

“… the literature showed the practice of prescribing by non-medical prescribers to be effective to increase access to health services and provide equitable and timely access to medications.” (page 8)

However, there is very little information, let alone evidence, upon which to be certain that non-medical prescribing will result in the quality use of medicines, improve the effectiveness of healthcare services or indeed improve overall health outcomes for patients.
Health reform policies should be made on the basis of evidence. The NHWPRC report highlighted on page 8 that:

“The quality of research into non-medical prescribing is generally poor and methodological quality was criticised in review articles.”

It is concerning that the expansion of non-medical prescribing is being proposed using ‘generally poor’ research papers that were based on self-assessment surveys completed by non-medical health practitioners.

There is also no evidence that non-medical prescribing is cost-effective. There has been no consideration of the potential financial impact, for example, through increased costs outlays under the Pharmaceutical Benefits Scheme that could result from non-medical prescribing. It cannot be assumed that non-medical prescribing will result in prescriptions being written by a ‘substitute prescriber’. Unless non-medical prescribing occurs in a medically delegated environment, there is every chance that more prescriptions will be written as a direct result of a greater number of prescribers.

**Safety and quality**

It is a concern that there is currently no consistent approach to accreditation of education and training courses for non-medical prescribing, or the way in which non-medical health practitioners may safely and competently prescribe within their recognised scope of practice. Because of this, there should be no ‘grandfathering’ of health practitioners into prescribing pathways or for registration purposes (i.e. endorsement to prescribe scheduled medicines).

The adverse events associated with the use of medicines is well documented. Independent prescribing by non-medical practitioners must be avoided: a physiotherapist prescribing a patient a nonsteroidal anti-inflammatory drug, but not being unaware of or understanding the danger to a patient already taking a combined ACE inhibitor and thiazide diuretic, can lead to dire consequences for kidney function.

A medically led and delegated team environment would ensure medical assessment of the patient, identification of risks and holistic decisions about patient management and care.

The AMA notes the proposal in the NHWPRC report for a framework of four models of non-medical prescribing. The AMA does not support this approach. In such a framework, over time non-medical practitioners in the lower levels of prescribing restrictions will seek escalation to higher levels. In addition, the AMA notes that Level 4 would require medical training and is therefore not an appropriate model for non-medical prescribing.

Instead, the AMA proposes a single framework in which the patient’s condition is diagnosed by a medical practitioner, and where clinically appropriate, delegation to a non-medical prescriber who can:

- prescribe by protocol or limited formulary;
- initiate therapy according to protocol and symptoms; and or
- continue, discontinue and maintain therapy according to a pre-approved protocol.
Scopes of practice, professional boundaries and communication

Protocols, formularies and guidelines that clearly document the roles, responsibilities and scopes of practice for non-medical practitioners and the roles of medical practitioners within the clinical unit are widely used in public hospital settings. These can be applied to non-medical prescribing in private settings.

These documents ensure that there are clear lines of professional boundaries and responsibilities and specify the form, timing and circumstances of communication according to the specific clinical context. Protocols ensure that prescribing occurs only within the health practitioner’s scope of practice and ensures patients are referred to another health practitioner when the patient’s clinical condition is outside scope of practice. Protocols also ensure that patients are assessed by a medical practitioner when their condition fails to improve.

There is considerable work to be done to use the best of the existing public sector protocols to develop nationally consistent protocols and formularies that can be used in public and private settings and in each jurisdiction. The AMA recommends that the National Lead Clinician Group oversee this work.

Education and training, accreditation and registration

Education and training curricula for prescribing by non-medical practitioners must include organic and inorganic chemistry, physiology, biochemistry and anatomy. Completion of education and training should produce core competencies in knowing when to prescribe, but also when not to prescribe.

The National Registration and Accreditation Scheme has provided the opportunity to develop uniform accreditation standards for non-medical prescribing education and training courses. The overarching objective should be that all non-medical prescribers are trained to the same standards, even though their prescribing is limited to their profession and their scope of practice.

If HWA is to achieve the objective of the project, it should seek to obtain a commitment from each of the relevant National Boards to set the same accreditation standards for education and training for non-medical prescribing. To date, the National Boards have set disparate registration standards for endorsement for scheduled medicines. These standards will need to be re-set if there is to be a nationally consistent approach to non-medical prescribing.

Accreditation of education and training courses for non-medical prescribing should be to the same standard used by the Australian Medical Council (AMC) to accredit medical education and training. Some may see this as setting the bar too high. However, given the well documented rates of adverse medication events, it is critical for patient safety that education and training for non-medical prescribing in Australia is of the highest order.

In respect of endorsement for scheduled medicines, it is disappointing that some National Boards have not seen fit to set standards that endorse registered practitioners only for their scope of practice. The result of this is that individual practitioners can self-define their scope of practice,
and their collaborating colleagues have little or no ability to independently verify that the individual is practising within a scope of practice that they are trained to prescribe in. This will need to be rectified so that patient safety can be protected in a medically led and delegated team environment. For example, a nurse practitioner working in the field of mental health who has undertaken accredited prescribing training appropriate to that field, should only be endorsed for prescribing in that field of practice.

The AMA considers that the development of a single set of accreditation standards for non-medical practitioner prescribing education and training is a high priority. In addition, there should be no further ‘grandfathering’ of non-medical practitioners for endorsement of scheduled medicines until these standards are set and education and training courses are accredited against those standards.

**Implementation and evaluation**

The consultation paper does not deal with medico-legal issues and the level of adequate indemnity cover for non-medical prescribers. At this time, medical practitioners carry the greatest exposure to medico-legal risks arising out of non-medical prescribing. Development of national protocols, formularies and guidelines will go a long way to mitigating the risks of medico-legal actions against medical practitioners and to non-medical prescribers. High quality education and training will do the same. In addition, indemnity insurers will be better placed to assess the insurance risk of these activities. The AMA recommends that HWA give this issue more detailed consideration as the project progresses.

The prescribing pathway project must be accompanied by a planned evaluation. There must be a detailed plan about what will be evaluated, how, by whom and when. Evaluation is critical to filling the current evidence gap on non-medical prescribing. By gathering data and analysing safe, quality and effective non-medical prescribing, it will be possible to determine the appropriate and inappropriate models, where the cost effectiveness truly lies, what the impacts on health outcomes are, and what mechanisms ensure prescribing standards are maintained.

The AMA recommends HWA establish an expert advisory group to establish the evaluation, in consultation with the health professions, and to provide public reporting of the analysis and outcomes.

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